# A NOTE ON ANTI-SYPHILIS MEASURES IN UGANDA

BY

CAPTAIN G. J. KEANE, R.A.M.C., M.D., D.P.H., D.T.M.

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Syphilis had become recognised to be so prevalent and its effects on the vital statistics of the native population so serious, that in 1907 Government took special steps to check the spread of the disease. The gravity of the situation will be realised when it is understood that the sterility of the Baganda women is remarkable, that abortion is very common, that of those children born alive, only the minority survive the first year of life.

The infantile mortality rate is apparently rarely below 50 %, and sometimes reaches as high as 80 %.

The general death-rate in many parts of the country exceeds the birth-rate.

In these circumstances the extinction of the Baganda race is obviously seriously threatened. In view of these facts the late Colonel F. J. Lambkin, R.A.M.C., was sent to Uganda to report on the subject. His investigations confirmed the reports of the extent of the ravages of the disease, and he made certain recommendations with regard to measures to be adopted. These included the sending of a certain number of special medical officers to treat syphilis on a large scale by means of intra-muscular injections. Their objects were, to report further on the prevalence of the disease, to see if intra-muscular injections could be successfully carried out on a large scale and report on their efficacy, and to observe whether a sufficient attendance of infected could be secured by appealing to the intelligence of the people through their chiefs.

The Baganda are unquestionably a most superior race, indeed they have been called, 'the Japanese of Africa'; their chiefs are very astute, and are keenly alive to the uncertainty of the future of their population.

## RESULTS

The first conclusion established, was, that complete treatment, as we know it in Europe, i.e., 21 months, was not feasible with the native population, and that there was good ground for questioning how far it could be said to be immediately necessary amongst the Baganda. The chief explanation of native disinclination to long-continued treatment was that, in the majority of cases, all active signs had disappeared at the time of completion of the second course of injections. The native could not see the force of persisting in treatment when he no longer had symptoms.

Other reasons of impracticability of long attendance were: the native custom of 'visiting'; all Baganda like to take long journeys up country at times, hence a break in their attendance. Further, every native has to perform labour for his chief, and in the ordinary way for earning livelihood and payment of tax.

The remarkable feature of all cases was the immediate response to treatment that took place. Commonly, all signs had disappeared at the completion of six injections. The suppression of symptoms was seemingly permanent in many cases. I had the opportunity of observing certain cases of well-marked secondary syphilis, who had only received one or two courses of injections, who at the end of that time were free from signs, and who to my certain knowledge remained so for fifteen months afterwards, although receiving no further treatment.

These observations, if confirmed by further experience, would be of great importance for the prospects of the success of this work in Uganda. Such persons cannot be said to be entirely cured, that is to say, they are immune from fresh infection, and being free from signs are presumably incapable of directly transmitting the disease. The occurrence of congenital syphilis is not precluded, except in so much as the spread of acquired syphilis is militated against. But an important step in the work of prevention of the spread of the disease is taken. The completion of treatment is rather the affair of the individual than a matter of public concern.

The second point established was that, short of some legislative assistance, a sufficient attendance of sick could not be secured. Thus, after eighteen months' work at Kampala, the attendances

dropped off considerably, and all the efforts of the chiefs failed to bring up the numbers of the sick to such a level as to justify the officers engaged there continuing the work.

Just before this time, I had commenced work at an out-station, Masaka. Here there was an Administrative Officer, administering a very large population, in which there was reported to be a high prevalence of venereal disease, assisted by a very capable and intelligent chief, named the Pokino. I continued the work here for a further eighteen months. When the Pokino was informed of the proposed anti-venereal disease measures to be adopted amongst his people he expressed his pleasure, and extended hearty co-operation. He built the hospital buildings, shown in the accompanying photographs, at his own expense, also some 200 huts for the accommodation of sick. He arranged for food supply for the sick.

The attendance at Masaka was always numerous, but not as high as it ought to have been from the point of view of influencing the incidence of the disease per 1,000 population, nor as numerous as I had arrangements made for. I could easily have treated seven to ten times the actual numbers.

Treatment never seemed to be in any way resented by the native population. It was admitted that the white man had a wonderful remedy, and the cases that did attend invariably expressed astonishment and gratitude at their rapid recovery.

The explanation of non-attendance seemed to be indifference; indifference on the part of the sick to the consequences of the neglect of the disease, and indifference to the danger that they themselves constituted to the healthy.

Thus I found that it was common to find a case of advanced secondary syphilis, with a pustular rash, living in a crowded house, his presence in this condition seeming to be in no way resented by his companions.

## TREATMENT

From the purely medical, therapeutic point of view, the work has been a complete success.

Nearly all cases treated were in the secondary stage.

Tertiary syphilis is relatively uncommon, and is confined chiefly

to cutaneous ulceration. Lesions of the nervous system and parasyphilitic conditions are rare.

Treatment in all adult cases consisted in intra-muscular (gluteal) injection of Lambkin's Mercurial Cream.

Six injections were administered at intervals of one week, then followed a rest-period of one month, then a further course of four weekly injections, followed by four weeks' rest and so onwards for as long as patient could continue attendance.

The intra-muscular method was entirely satisfactory clinically, as the accompanying photographs show. In practice, it is an extremely rapid and convenient method of treating large numbers. I found I was able, with trained native assistance, to inject and make entries in case-sheets at the rate of sixty patients per hour. During three years' almost daily use of the method I had only one case of gluteal abscess.

Jeyes' Fluid was used for the preliminary preparation of the skin.

All the routine work, the dispensing, preparation of stock solutions, writing up of case-books, dressings and local applications, were carried out by native assistants.

The Baganda are remarkably apt pupils, they write and speak English well; they make good type-writers.

The organisation of specially trained native hospital assistants will, I hope, be an important feature of the campaign against venereal disease in Uganda.

The dose given in all cases was 1/5th grain of the Lambkin Mercurial Cream. Higher doses constantly resulted in salivation without any other notable results.

I wish to express my indebtedness to Dr. A. D. P. Hodges, C.M.G., Principal Medical Officer, Uganda Protectorate, for kind permission to publish, and to Captain E. B. Place, District Commissioner, Masaka, for taking the accompanying photographs.

## EXPLANATION OF PLATES

### Plate VII

Fig. 1. General view of arrangement of a Venereal Treatment camp; below are seen lines of temporary huts for accommodation of sick.

Fig. 2. Nearer view of sick lines.

Fig. 3. An average morning attendance at Masaka.

Fig. 4. Chancre penis; commencing rash seen.

Fig 1.

Fig. 2.

Fig. 3.

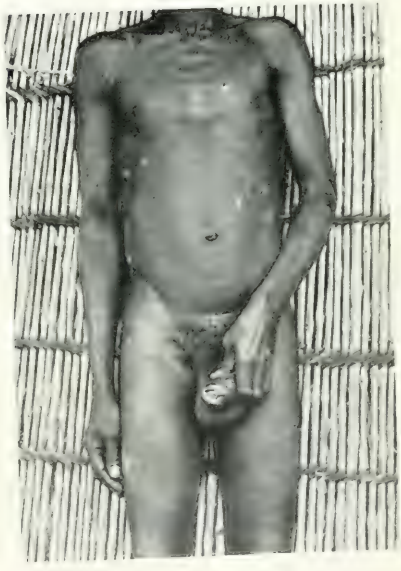

Fig. 4.

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## Plate VIII

Fig. 5. Case 230; on admission.

Fig. 6. Case 230; after two injections only.

Fig. 7 and 8. Secondary and congenital syphilis; on admission and after treatment. The woman and child in Fig. 8 are the same as those on the left in Fig. 7. Fig. 8 is made from a photograph taken after the woman's head had been shaven.